

**A Particular Perspective: A Brief and Personal History of the Response to  
Publication of the 5<sup>th</sup> Edition of the Diagnostic and Statistical Manual of the American  
Psychiatric Association**

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### Abstract

The idea and practice of ‘diagnosis’ in psychiatry has always been controversial. Controversy came to a head in the period preceding and immediately after publication of the latest version of the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders*, DSM-5. There was widespread international discussion and debate not only in scholarly journals but in mainstream and social media, and to the formation of International DSM Response Committee and an International Summit on Psychiatric Diagnosis. This article documents that process and outlines the issues that provoked, and continue to provoke most controversy, from the (admittedly personal) perspective of those involved. It ends with suggestions of alternatives to diagnosis, which avoid some of these problems and outlines how these are being taken forward. The next ten years are likely to see significant change.

*Keywords:* DSM-5, history, criticism, opposition, response

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**Psychiatric diagnosis in social and political context**

Psychiatric diagnosis has always been a contentious issue, but the storm of controversy that attended the development and release of the most recent version of the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-5: American Psychiatric Association, 2013) was without precedent. This paper describes the history of opposition to these reforms, between 2011 and 2015. The latest revision of the DSM franchise will be placed in a historical context, including the influence of social and political factors on the various editions over time. However, this paper will particularly focus on the activities undertaken by members of the British Psychological Society and Division 32 (the Society for Humanistic Psychology) of the American Psychological Association. As such, it must be seen as a personal and narrative account rather than an independent and neutral historical analysis.

Psychiatric diagnosis has always been controversial, and has never remained the same for long. A rather remarkable editorial in the London Times of Saturday July 22nd, 1854, commenting on the question of madness in a notorious criminal case, stated that:

“Nothing can be more slightly defined than the line of demarcation between sanity and insanity. Physicians and lawyers have vexed themselves with attempts at definitions in a case where definition is impossible. There has never yet been given to the world anything in the shape of a formula upon this subject which may not be torn to shreds in five minutes by any ordinary logician. Make the definition too narrow, it becomes

meaningless; make it too wide, the whole human race are involved in the drag-net. In strictness, we are all mad as often as we give way to passion, to prejudice, to vice to vanity; but if all the passionate, prejudiced, vicious, and vain people in this world are to be locked up as lunatics, who is to keep the keys to the asylum?" (p. 2).

Psychiatric diagnostic criteria are revised regularly. It is often assumed that these changes are driven by scientific advances – an enlightened movement from falsehood to objective clarity. But it makes more sense to see our classificatory systems in mental health as historical technological documents, whose development has been driven by the current social, political, economic and other forces (Foucault, 1967). Despite our hope (or contention) that the frequent updates of diagnostic manuals reflect scientific progress (Kendler, 2014) we might better regard such changes as indicative of the socio-political needs and values of the time (Bowker & Star, 1999, Fulford, Thornton and Graham, 2006; Scott 1990). The 1854 example quoted above is remarkable in the degree to which it reflects the 21<sup>st</sup> century concerns about the role of psychiatric diagnosis addressed later in this paper. These questions arose in 1854 in the context of a horrific murder, which challenged contemporary beliefs about the nature of mental health and illness. The ‘the line of demarcation between sanity and insanity’ has been constantly questioned since 1854. Social forces ebb and flow, and our approaches to psychiatric diagnosis change with them.

In that context, it seems appropriate to set out some of the chronology and political history of, debate about, and opposition to the most recent reforms of the American Psychiatric Association’s Diagnostic and Statistical Manual (DSM), namely the development of DSM-5 between 2011 and 2015.

**1956-1994: DSM-I to DSM-IV**

The first editions of the Diagnostic and Statistical Manual for Mental Disorders (DSM-I, 1952; DSM-II, 1968) are widely held to reflect the political and social needs facing the US Veterans Administration at the end of the Second World War (e.g. Pilgrim, 2014). There was a clear need to identify and respond to the mental health problems of large numbers of returning servicemen (many of whom had been traumatized by war and in any event required an efficient service). The problems experienced by veterans were a clear demonstration of the role of social and environmental factors in mental health. This, together with the psychodynamic and psychoanalytic approaches popular at that time (American Psychiatric Association, 2015) led to pressure to conceptualise mental health problems in a rather more inclusive manner than merely to isolate the ‘insane’ in asylums (Grob, 1991). Subsequent revisions, namely DSM-III (1980) and DSM-IV (1994) have been argued to reflect something of a crisis of legitimacy for psychiatry, with the significant changes introduced in DSM-III seen as a desire to align mental disorders more closely with physical illnesses (Mayes & Horwitz, 2005). Many have commented that just as DSM-I reflected the social needs of the Veterans Administration at the end of WWII, these changes may reflect the political and financial needs of professional bodies, and insurance and pharmaceutical companies (Mayes & Horwitz, 2005; Tsou, 2011, Pilgrim, 2014).

With regard to specific diagnoses, it is noticeable that over the history of the DSM, some diagnoses have been removed (hysteria, homosexuality), some experiences (gender dysphoria, hearing voices) have changed from being seen as inherently pathognomic towards being seen as pathological only if the individual finds them distressing. Equally, some diagnoses appear to have been created primarily for political purposes, for example post-traumatic stress disorder and ‘dangerous and severe personality disorder’ (Pickersgill, 2013) – this latter being a peculiarly

UK phenomenon and not present in DSM-IV or DSM-5, but illustrative of the point. These changes appear to have had more to do with social and cultural movements than with scientific progress. For example, although the reasons for the removal of hysteria as a diagnosis are complex, a significant contributing factor appears to have been the rise and development of women's rights and changing gender roles in the 20th Century (Ussher, 2013). Similarly, the initial inclusion of homosexuality as a diagnostic category (in the first edition of the DSM in 1952), its subsequent removal in 1974, and the later removal of 'ego-dystonic' homosexuality from the DSM-III-R in 1986, all appear to reflect political and social changes: the first legislation to decriminalize homosexuality was passed in the US in 1962 and in England and Wales in 1967 in response to the rise of gay rights campaigns (Kutchins & Kirk, 1997, Pilgrim, 2014). Recently, the World Health Organization has called for the removal of all disease categories in the forthcoming ICD-11 that relate to sexual orientation (Cochran & Drescher, 2014). Again reflecting civil rights movements, similar changes can be seen in diagnostic criteria for so-called 'personality disorder' (itself a contested term) in response to changing cultural norms about 'obscene language' and 'monogamous relationships' (Wakefield, 1996), and complex changes to the definitions and nomenclature of 'paraphilias' (Wakefield, 2013).

As some diagnoses disappear, others emerge. Post-traumatic stress disorder (PTSD) was first introduced in DSM-III (American Psychiatric Association, 1980) and has been seen as a response to the aftermath of the Vietnam War. By receiving an PTSD diagnosis, traumatized veterans could access medical or psychological care, whilst avoiding both the stigma of other psychiatric diagnoses on the one hand, and criticisms of malingering or cowardice on the other (Scott, 1990, Galatzer-Levy & Bryant, 2013, Helzer, Robins, & McEvoy, 1987). In the UK, perhaps one of the more interesting introductions (although not, admittedly, into the DSM) was

that of ‘dangerous and severe personality disorder’. This was initially merely an ‘administrative category’ rather than a clinical diagnostic category, created by officials in the criminal justice system in the UK in 2001 as a response to public anxiety around high-profile cases of assault and homicide. It acted as a focus for the provision of treatment with the aim of reducing reoffending (Ministry of Justice, 2011, Burns et al., 2011). The impetus for introducing such a category was overtly political, namely a wish to combine public protection, punishment, and treatment in a context of public fear and risk aversion (Manning, 2002). Although administrative, in that it was never introduced into any clinical diagnostic manuals, it is clear that the label was taken up both from research and lay perspectives as if it were a diagnosis. For example journal articles referred to ‘the treatment of individuals with dangerous and severe personality disorder’ (Völlm & Konappa, 2012) and in a House of Commons ‘Written Answer’; “To ask the Secretary of State for Justice how many (a) adult and (b) juvenile prisoners have been diagnosed with dangerous and severe personality disorder” (Parliamentary Written Answers, 2008; Column 906W).

In that context, it is important to bear in mind that psychiatric diagnoses are shaped by, and shape, our understanding of social norms, diversity and difference what it means to be deviant (Pickersgill, 2013; Pilgrim, 2014). Such classificatory systems also speak to how we understand (perhaps, even, how we allow ourselves to recognize) the psychological impact of adversity and social deprivation. As such, comments on psychiatric diagnoses are often social and political statements.

### **1999-2011: revision of DSM-IV to DSM-5**

To recap, there have been five revisions of the DSM since it was first released in 1952, with the previous major revision, DSM-IV, published in 1994. The 19-year period between the

introduction of DSM-IV in 1994 and the final publication of DSM-5 in 2013 was, therefore, relatively long. The planning process for DSM-5 began within the American Psychiatric Association in 1999 (see American Psychiatric Association, 2014 for an official ‘timeline’) with the publication of a number of ‘white papers’ detailing proposed reforms, and discussion at professional conferences. The initial proposed revisions went out to APA members and all other interested parties in a public consultation in 2011. At the same time, so-called ‘field trials’ of proposed new diagnostic criteria were started in a number of healthcare and academic settings (Clarke, Narrow, Regier DA, et al., 2013; Regier, Narrow, Clarke, et al., 2013; Narrow, Clarke, Kuramoto, et al., 2013). These were to run through to 2012 (American Psychiatric Association, 2014).

### **2011: Public Consultation on the DSM reform proposals in 2011 and the British Psychological Society’s response.**

In the spring of 2011, the American Psychiatric Association posted their draft (revised) diagnostic criteria on a public website and opened a two-month period of public consultation. The British Psychological Society (BPS) took the opportunity to respond in June 2011 (British Psychological Society, 2011). The BPS response was prepared by the current first author (PK), with contributions from Susan van Scoyoc, David Harper, David Pilgrim, Richard Bentall, Lucy Johnstone, Amanda Williams and Pamela James and subsequently consulted upon widely among members, before being considered, edited and approved by relevant Boards of the British Psychological Society. In addition to specific comments, it included the general statement that:

“The Society is concerned that clients and the general public are negatively affected by the continued and continuous medicalisation of their natural and normal responses to



their experiences; responses which undoubtedly have distressing consequences which demand helping responses, but which do not reflect illnesses so much as normal individual variation” (p. 2).

This general – although powerful – expression of concern was elaborated in detailed responses to the proposals as apparent at the time of writing, and in more general statements regarding the theoretical framework employed. For example, the BPS commented:

“The putative diagnoses presented in DSM-V (sic) are clearly based largely on social norms, with 'symptoms' that all rely on subjective judgements, with little confirmatory physical 'signs' or evidence of biological causation. The criteria are not value-free, but rather reflect current normative social expectations. Many researchers have pointed out that psychiatric diagnoses are plagued by problems of reliability, validity, prognostic value, and co-morbidity. Diagnostic categories do not predict response to medication or other interventions whereas more specific formulations or symptom clusters might (Moncrieff, 2007). ... Diagnostic systems such as these therefore fall short of the criteria for legitimate medical diagnoses. .... We are also concerned that systems such as this are based on identifying problems as located within individuals. This misses the relational context of problems and the undeniable social causation of many such problems. For psychologists, our wellbeing and mental health stem from our frameworks of understanding of the world, frameworks which are themselves the product of the experiences and learning through our lives” (p. 2).

The BPS response continued:

“The Society recommends a revision of the way mental distress is thought about, starting with recognition of the overwhelming evidence that it is on a spectrum with 'normal'

experience, and that psychosocial factors such as poverty, unemployment and trauma are the most strongly-evidenced causal factors. Rather than applying preordained diagnostic categories to clinical populations, we believe that any classification system should begin from the bottom up – starting with specific experiences, problems or ‘symptoms’ or ‘complaints’. Statistical analyses of problems from community samples show that they do not map onto past or current categories (Mirowsky, 1990, Mirowsky & Ross, 2003). We would like to see the base unit of measurement as specific problems (e.g. hearing voices, feelings of anxiety etc). These would be more helpful too in terms of epidemiology.

While some people find a name or a diagnostic label helpful, our contention is that this helpfulness results from a knowledge that their problems are recognised (in both senses of the word) understood, validated, explained (and explicable) and have some relief.

Clients often, unfortunately, find that diagnosis offers only a spurious promise of such benefits. Since – for example – two people with a diagnosis of ‘schizophrenia’ or ‘personality disorder’ may possess no two symptoms in common, it is difficult to see what communicative benefit is served by using these diagnoses. We believe that a description of a person’s real problems would suffice. Moncrieff and others have shown that diagnostic labels are less useful than a description of a person’s problems for predicting treatment response, so again diagnoses seem positively unhelpful compared to the alternatives. There is ample evidence from psychological therapies that case formulations (whether from a single theoretical perspective or more integrative) are entirely possible to communicate to staff or clients. We therefore believe that alternatives to diagnostic frameworks exist, should be preferred, and should be developed with as

much investment of resource and effort as has been expended on revising DSM-IV. The Society would be happy to help in such an exercise” (p. 3).

Further, more detailed critique suggested that; “classifying these problems as ‘illnesses’ misses the relational context of problems and the undeniable social causation of many such problems” (p. 2), and stated that the Society was “very concerned at the increasing use of this diagnosis and of the increasing use of medication for children, and would be very concerned to see these increase further” (p. 4). As illustrative examples, the BPS also raised particular concerns about diagnoses such as ‘Chronic Depressive Disorder (Dysthymia)’, arguing that:

“... sadness and unhappiness ... are deserving of help and intervention [but] are not best considered illnesses. We also note that, by regarding them as such, there is a danger of misunderstanding their nature and cause and applying inappropriate medical remedies. We have particular concerns at the inclusion of this diagnosis, whose essential characteristics: “...depressed mood for most of the day...” certainly reflects a state of affairs that any humane individual should attempt to address, but does not appear to reflect any form of medical illness” (p. 14).

In responding to the putative diagnosis of ‘Disruptive, Impulse Control and Conduct Disorders’, the BPS commented that:

“Of particular concern are the subjective and socially normative aspects of conformist behaviour. We are very concerned that ‘headstrong’ behaviour is considered to be pathognomic of an illness (in Oppositional Defiant Disorder). Many people – many governments – would like children and citizens to be less defiant and more compliant. However, it is not a symptom of illness to be defiant. It may be a social or psychological

problem to be addressed, but it may, in some circumstances, be a characteristic to be praised” (p. 22).

Other concerns addressed ‘Substance Use and Addictive Disorders’ where the Society commented that:

“We note with concern the concept of ‘Gambling Disorder’. Gambling is a problem, and it is a social phenomenon and issue that requires study and response. However, we feel it is conceptually wrong to regard this as an illness with symptoms” (p. 23).

Of particular concern to the BPS was the proposed diagnosis of ‘Paraphilic Coercive Disorder”, where the Society commented that:

“Rape is a crime, not a disorder. Such behaviours can, of course, be understood, but we disagree that such a pattern of behaviour could be considered a disorder, and we would have grave concerns that such views may offer a spurious and unscientific defence to a rapist in a criminal trial” (p. 25).

### **2011: Psychological Association Division 32 (Society for Humanistic Psychology) ‘Open Letter’**

In October 2011, Division 32 of the American Psychological Association published an ‘Open Letter’ (<http://www.ipetitions.com/petition/dsm5/>), citing the British Psychological Society and launched a petition expressing concerns about the proposed revisions to DSM-IV. This Open Letter drew heavily upon the BPS response detailed above and published only a few months earlier. It argued that psychologists, as “...consumers and utilizers of the manual, but ... also producers of seminal research ...” should be included in the development of DSM-5 “... as a professional community” (section 1).

As the BPS had done, the APA Division 32 also expressed concerns about "... the lowering of diagnostic thresholds for multiple disorder categories, about the introduction of disorders that may lead to inappropriate medical treatment of vulnerable populations, and about specific proposals that appear to lack empirical grounding" (section 2; 'Overview'). It drew attention to proposed changes that threatened to "... deemphasize sociocultural variation while placing more emphasis on biological theory" (section 2; 'Overview'). The authors continued:

"In light of the growing empirical evidence that neurobiology does not fully account for the emergence of mental distress, as well as new longitudinal studies revealing long-term hazards of standard neurobiological (psychotropic) treatment, we believe that these changes pose substantial risks to patients/clients, practitioners, and the mental health professions in general" (section 2; 'Overview').

In particular, the Open Letter suggested that there were risks to vulnerable people, especially children, adolescents and the elderly, and people with political, religious, or sexual behaviours not shared with majority cultures. It therefore proposed that there was a need for "...a descriptive and empirical approach that is unencumbered by previous deductive and theoretical models" (section 2; 'Overview').

Shortly after the publication of the Open Letter, officials of Division 32 (David Elkins, Brent Dean Robbins and Sarah Kamens) wrote to a number of international colleagues, proposing a 'coalition of major psychology organizations' to 'address the DSM-5 concerns. It is worth pointing out in this context, however, that many of the most trenchant critics of DSM-5 did not come from 'psychology organizations' but were, rather, psychiatrists acting collaboratively with service users and charities (see, for instance, signatories to the petition at <http://www.ipetitions.com/petition/dsm5/>).

**2011-2013: DSM-5 Response Committee and related activity**

In the months from the autumn of 2011 to the early weeks of 2013, a variety of individuals and groups expressed concerns about – and support for – the proposed revisions to DSM-IV. One notable critic was psychiatrist Allen Frances, who had served as Chair of the committee that had drawn up DSM-IV. There are many aspects to Frances' response to the DSM-5 proposals. Many of his comments (see, for example; Frances, 2011 October 24) reflect those of the British Psychological Society and of Division 32 of the American Psychological Association, as well as those of other prominent psychiatric critics (see, for example; Thomas, 2013, Double, 2013, Kinderman, Read, Moncrieff & Bentall, 2013, or Timimi, 2012). For example, Frances called the petition: “an extremely detailed, thoughtful, and well written statement that deserves your attention and support” (introductory paragraph). He went on to say that it:

*“...summarizes the grave dangers of DSM-5 that for some time have seemed patently apparent to everyone except those who are actually working on DSM-5. The short list of the most compelling problems includes: reckless expansion of the diagnostic system (through the inclusion of untested new diagnoses and reduced thresholds for old ones); the lack of scientific rigor and independent review; and dimensional proposals that are too impossibly complex ever to be used by clinicians”* (paragraph 2).

Frances' involvement in and support for such a campaign was undeniably significant. The fact that Frances was a major US psychiatrist was particularly important since the campaign related to a project being undertaken by the American psychiatric establishment. He was also well known as the Chair of the DSM-IV drafting committee, and as such could be seen to have

distinctive specialist knowledge. As an individual, Allen Frances also had great energy and enthusiasm, together with good media skills. In the months before and after the publication of DSM-5 Frances gave a large number of media interviews and his involvement was undoubtedly a major factor in the development of a high level of awareness in journalistic circles.

Aspects of Allen Frances' critiques of the proposed revisions were, however, disputed by some. Some suggested that he was motivated the threat to DSM-IV royalty income (Greenberg, 2010) especially when France advocated a petition to boycott DSM-5, a move which would have left most US-dominated healthcare institutions reliant on DSM-IV. Less personally, Frances' line sat somewhat uneasily with the majority of the leading figures in the emergent campaign groups, who tended to hold the view (first expressed by the BPS) that this issue was not so much whether DSM-5 was a technically better manual than DSM-IV but the more fundamental issue of whether the whole idea of 'diagnosis' and the language of 'disorder' are very meaningful or useful in mental health, or unhelpfully medicalize what are largely psychosocial problems. These critics tended to think that, while the proposed revisions to DSM-5 were a retrograde step, DSM-IV had been little better in this regard. Despite this, Frances' involvement in and support of the campaign was a major asset.

As the campaign developed, led primarily by office-holders in the BPS and APA Division 32, it drew international support. Although many professional psychological organizations decided that it would not be appropriate for them to campaign on this issue, opposition to the proposed changes to DSM was widespread in Europe, especially in France, where the leadership of the psychiatrist and psychoanalyst Patrick Landeman was key (see, for instance 'COLLECTIF39', 2015).

By the beginning of 2013, with the publication of DSM-5 scheduled for May of that year, the campaign had developed to become the ‘DSM-5 Response Committee’. A petition of support associated with the APA Division 32’s ‘Open Letter’ of October 2012 had, by February 2013, attracted the support of more than 50 mental health organizations and over 14,000 individual signatures. Representatives of a number of international psychological and mental health organisations were contacted by Brent Dean Robbins and Peter Kinderman to gather support for a ‘Statement of Concern’ regarding DSM-5. The decision to ask for support for a ‘statement of concern’ was essentially pragmatic and consensual. Some colleagues, such as Jack Carney and Patrick Landeman (see <http://boycott5committee.com/>) but also (presumably for different reasons) Allen Frances, advocated a boycott of DSM-5. Others took a more pragmatic view, arguing that such a call was unlikely to prove effective because of the entrenched position of diagnostic manuals such as DSM in the healthcare economy, and instead suggesting that (in the words of the organizers): “it is vitally important to alert our colleagues, the mass media, and consumers about some serious reservations with the current draft of the DSM-5” (introductory paragraph). In its entirety The ‘Statement of Concern’ (DSM-5 Response Committee, 2013) ran as follows:

We believe that there is now overwhelming evidence that DSM-5:

- Is the result of a secretive, closed, and rushed process that put publishing profits ahead of public welfare;
- Is in many places scientifically unsound and statistically unreliable, and did not receive a much needed and widely requested external scientific review;
- Is clinically risky because of many new and untested diagnoses and lowered diagnostic thresholds



- Will result in the mislabeling of mental illness in people who will do better without a psychiatric diagnosis
- Will result in unnecessary and potentially harmful treatment with psychiatric medication;
- Will divert precious mental health resources away from those who most need them.

For these reasons, we have serious concerns about the new DSM-5 scheduled for publication by the American Psychiatric Association on 20th May, 2013.

These concerns should be resolved through concerted, interprofessional, international dialogue. Such dialogue should involve detailed critique of these proposals, consideration of possible alternatives, including non-medical approaches such as the problem-focused approach and individual case formulation used in evidence-based psychological therapies. There should be comprehensive, peer-reviewed, scientific field testing of any proposed suggestions.

Until these issues have been addressed, we believe that clinicians should not use DSM-5 in their clinical decisions and communications wherever possible. Wherever possible, researchers should choose not to use the scientifically unsound DSM-5 categories as the basis of their studies, especially as such invalid diagnoses may compromise their own findings. We believe that, due to the availability of safe and legal alternatives, healthcare planners, managers, and commissioners have no need to use DSM-5 for planning or billing purposes. Colleagues in the pharmaceutical industry should avoid the use of DSM-5 diagnostic codes in planning, conducting or reporting their work, especially as they bear little relationship to underlying biological mechanisms. In addition, journal editors should consider whether it is appropriate to publish scientific papers that

unquestionably assume the reliability and validity of DSM-5 diagnostic categories.

Finally, the media should be aware of the scientific, theoretical, and ethical problems in DSM-5 when reporting on mental health issues” (full text).

While the DSM-5 Response Committee therefore stopped short of calling for a boycott of DSM-5, its clear aim was to alert media organizations, prior to and on publication of DSM-5, that the issue of psychiatric diagnosis, especially as characterized in that proposed revision, was a very contentious one.

**May 18<sup>th</sup> 2013: Publication of DSM-5 together with academic and media commentary.**

The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the DSM-5, was approved by the Board of Trustees of the American Psychiatric Association on December 1<sup>st</sup> 2012 (<http://www.dsm5.org/about/Pages/Timeline.aspx>) and published on May 18<sup>th</sup> 2013.

It is perhaps merely a reflection of global politics and the dominance of the English language, but the American Psychiatric Association’s DSM manual has become routinely referred to as a ‘bible’ of psychiatry (e.g. <https://www.corbette-report.com/meet-the-dsm-big-pharmas-psychiatric-bible/>), and consequently the publication of a new edition attracted considerable international academic and media attention. It is not possible to list all academic and media commentaries here, but a few selected examples may be illustrative.

Kinderman, Read, Moncrieff and Bentall (2013) called for mental health workers and academics to ‘drop the language of disorder’, arguing that clinicians and researchers are: “likely to be more effective if they respond to an individual’s particular difficulties rather than their diagnostic label” (p. 3). That this position reflects that of the DSM-5 response committee is

perhaps unsurprising given that some of these authors were committee members. Rather more independently, both *The Lancet* and the *British Medical Journal* (UK-based, but nevertheless very influential medical publications) published editorials expressing significant concerns about DSM-5. An editorial in *The Lancet* (Lancet, 2012), published before the publication of the revised manual focused on the (then) proposed removal of an exclusion period before a diagnosis of ‘major depressive episode’ could be made in someone recently bereaved. The editorial commented that: “Grief is not an illness; it is more usefully thought of as part of being human and a normal response to death of a loved one” (p. 589), and “medicalising grief, so that treatment is legitimized routinely with antidepressants, for example, is not only dangerously simplistic, but also flawed” (p. 589). The Lancet did not expand on this analysis, and did not issue another editorial comment after the publication of DSM-5, but it seems clear that its analysis – at least with respect to the issue of grief – is consistent with that of the DSM-5 critics.

The *British Medical Journal* (BMJ), focused on the publication of DSM-5 in its edition of May 2013, with the cover-page title of ‘Too Many Labels? - the controversy over DSM-5’ (see Figure 1) and a feature article entitled “DSM-5: a fatal diagnosis? (Gornall, 2013). Although these articles covered much of the same material discussed above, it is significant that the BMJ chose to use the word ‘controversy’ and to frame its editorial in terms of the need for debate.

In an interesting sideline to these discussions, the Director of the US National Institute of Mental Health (NIMH), Thomas R. Insel, published a blog on April 29<sup>th</sup> 2013 (Insel, 2013) which was widely interpreted as being highly critical of DSM-5. In it, Insel wrote that: “The weakness [of DSM-5] is its lack of validity” ... “Patients with mental disorders deserve better”. He went further, suggesting that NIMH (a major and very influential funder of psychiatric and psychological research) would no longer use DSM-5 as the basis of its research, stating: “it is

critical to realize that we cannot succeed if we use DSM categories as the “gold standard”. Instead, Insel suggested, NIMH would use its own, different, system, the *Research Domain Criteria* (RDoC; NIMH, 2011). Insel's intervention, perhaps in the context of an audience already alert to ‘controversy’, fueled the debate, and the resulting headlines included "Goodbye to the DSM-V" (McKay, 2013), "Federal institute for mental health abandons controversial 'bible' of psychiatry" (Drummond, 2013), "National Institute of Mental Health abandoning the DSM" (Bell, 2013), "Psychiatry divided as mental health 'bible' denounced” in the widely-read New Scientist (Coghlan & Reardon, 2013) and – in the highly respected New York Times – “Psychiatry’s Guide Is Out of Touch With Science, Experts Say” (Belluck & Carey, 2013).

In a move which some found surprising and suspected was a reaction to the press coverage (e.g. Hickey, 2013) Insel subsequently issued a joint statement on behalf of NIMH with Jeffrey Lieberman, president of the American Psychiatric Association (Insel & Lieberman, 2013). In that statement – which appeared to many to be something of a volte-face for NIMH – the two authors stated that DSM-5: “... represents the best information currently available for clinical diagnosis of mental disorders. Patients, families, and insurers can be confident that effective treatments are available and that the DSM is the key resource for delivering the best available care. The National Institute of Mental Health (NIMH) has not changed its position on DSM-5.”

### **The controversy finds its way into popular culture**

Raising awareness of the controversy over the diagnosis of psychiatric ‘disorders’ was a key aim of the self-styled ‘DSM-5 Response Committee’, and a significant clause in its ‘Statement of Concern’ (DSM-5 Response Committee, 2013). This aim appears to have been

achieved: the idea that the development was controversial found its way into popular culture. In addition to the New York Times piece, (Belluck & Carey, 2013), perhaps the most striking example was its mention in the hugely popular animated series *The Simpsons*. In Episode 12 of Series 25, Bart Simpson meets a boy named Diggs (voiced by Daniel Radcliffe), whose eccentricities attract Bart but also require explanation. In conversation with Bart, Diggs comments: “The rumors of my bonkertude have been greatly exaggerated. DSM-5 indicates paranoid schizophrenia, but that work is mired in controversy. Mired.” (see Figure 2).



Figure 1, British Medical Journal cover for 25<sup>th</sup> May, 2013.



Figure 2, Screenshot of Simpsons Episode 12, Season 25, “Diggs”

## The Present

The campaign fought over the first few months of 2013 appears to have had a lasting impact. There is now an on-going and vigorous debate over the reliability, validity, utility, epistemological status and humanity of psychiatric diagnosis in general and of DSM-5 in particular. There now appears to be widespread realization that the issue of psychiatric diagnosis is indeed contentious. One example was perhaps the debate about the status and meaning of ‘depression’ that followed the death by suicide in 2014 of the actor Robin Williams (e.g. Cooke, Gilchrist & McGowan, 2014).

Another indication of the extent to which the debate has challenged the status quo has perhaps been the reaction to the publication by the British Psychological Society of its report *Understanding Psychosis and Schizophrenia* (Cooke, 2014: see also our second article in this special issue). Although unrelated to the publication of DSM -5 in that the document was a scheduled replacement for a previous one (British Psychological Society Division of Clinical Psychology, 2000), the report’s message was highly relevant: “Professionals should not insist

that people accept any one particular framework of understanding, for example the idea that their experiences are symptoms of an illness” (p. 6). Indeed, when the New York Times published a favorable piece on the report (Luhmann, 2015), former President of the American Psychiatric Association Jeffrey Lieberman mentioned above, was motivated to post a personal video blog. The blog was entitled “What Does the New York Times Have Against Psychiatry?” and showed him wearing a scientist’s white coat (Lieberman, 2015). In it, he criticized not only the New York Times article but also the original BPS report, suggesting that the material could have the effect of: “challenging the veracity of diagnoses and giving people who have symptoms of a mental disorder, license to doubt that they may have an illness and need treatment”. In the light of the above quote from the report, it may be that Lieberman has correctly interpreted this aspect of its message, but disagrees with it. Lieberman’s blog itself provoked widespread comment ranging from agreement (e.g. Pierre, 2015) to interpretation as evidence of a ‘crisis of legitimacy’ for psychiatry (e.g. Cornwall, 2015).

The widespread media coverage indicates that the debate about psychiatric diagnosis has entered the mainstream. There also appears to be a significant increase in the number of professional and popular books published which are critical of the diagnostic approach (e.g. Kinderman, 2014; Davies, 2013; Moncrieff, 2013; Cromby, Harper & Reavey, 2013).

The critiques are also increasingly reflected in professional guidelines. For example the British Psychological Society Division of Clinical Psychology’s recent ‘*Guidelines on Language in Relation to Functional Psychiatric Diagnosis*’ (British Psychological Society Division of Clinical Psychology, 2015); offer alternative forms of words to replace or supplement traditional diagnostic labels. It recommends ‘usages which attempt to describe behavior and experience in non-medical terms, and within its personal, interpersonal, social and cultural contexts. For

example, it suggests replacing ‘anxiety disorder’ with descriptions such as ‘fear, anxiety, worry, extreme anxiety’.

Despite the debate, support remains in many quarters for traditional psychiatric diagnosis. Much of this support is pragmatic and reasonable – many practitioners point out that, until we have workable alternatives, diagnosis serves some useful purposes (e.g. McGowan & Cooke, 2013). Other commentators appear unaware of the limitations of the traditional approach, and some appear to find it difficult to contemplate alternatives. A simple search of academic articles online reveals the widespread use of terms such as ‘heterogeneous diagnoses’, especially in relation to psychosis. Few authors appear to draw the logical conclusion that psychiatric diagnoses do not generally represent discrete phenomena. More worryingly, one (medically qualified) contributor to an on-line blog suggested that: “clinicians need to communicate to each other, and even a wrong diagnosis allows them to do so” (Paris, 2013). This seems a very odd defense – it suggests not only that clinicians could allow their care to be guided by ‘wrong’ diagnoses, but also that they should share their errors with colleagues.

## **The Future**

Proposals for radical change to mental health care continue. Both psychiatrists (e.g. Bracken et al, 2012) and psychologists (e.g. Kinderman, 2014) argue for reform; in the latter case arguing that: “... services should... be based on the premise that the origins of distress are largely social... should replace ‘diagnoses’ with straightforward descriptions of problems... should radically reduce use of medication, and use it pragmatically rather than presenting it as ‘treatment’, ... should tailor help to each person’s unique and complex needs... and should offer care rather than coercion. Mental health teams need to be radically different ... under local



authority control, and ... we must establish the social prerequisites for genuine mental health and well-being” (p. 191). From a slightly different perspective, the ‘OnlyUs’ campaign (OnlyUs Campaign, 2015) disputes the diagnostic distinction between ‘well’ and ‘ill’, arguing that: “... the uncomfortable truth [is] that there's a continuum, a scale along which we all slide back and forth during our lives, sometimes happy, occasionally depressed or very anxious; mostly well balanced but with moody moments; usually in touch with reality, but at times detached or even psychotic. When we separate ourselves and imagine humanity divided into two different groups, we hurt those labelled as sick, ill, even mad. We allow stigma, prejudice and exclusion to ruin potentially good and creative lives. But we also hurt ourselves, because we stress ourselves out with false smiles and the suppression of our own vulnerabilities. There is no them and us, there's only us” (OnlyUs Campaign, 2015).

As has been argued elsewhere (Cromby, Harper & Reavey 2013; Cooke, 2014; Kinderman, 2014) we need a wholesale revision of the way we think about psychological distress. We need to acknowledge that such distress is a normal, rather than abnormal, part of human life — that humans respond to difficult circumstances by becoming distressed. Such an approach recognizes that there is no easy ‘cut-off’ between ‘normal’ experience and ‘disorder’, and (as suggested in the 2011 BPS statement reported above) that psychosocial factors such as poverty, unemployment and trauma are the most strongly evidenced causal factors for psychological distress (Read & Bentall 2012).

While some people find a name or a diagnostic label helpful, our contention is that this is because of the implication that their problems are recognized (in both senses of the word), understood, validated, explicable and that help is available. In other words, within our current system and frames of reference, a psychiatric diagnosis is often the only way that someone in

distress can have three important needs met: validation (acknowledgement that they have a significant and understandable problem for which they are not to blame), income (access to sickness pay and/or disability benefits) and support (emotional and practical support from those around them, and professional help) (Cooke, 2013, Cooke & McGowan, 2013). Those of us working on developing alternatives need to bear in mind these important considerations, perhaps particularly in the current context of ‘austerity’ measures together with cuts to public services and social security. Nevertheless, alternatives are badly needed in view of the significant problems with the diagnostic approach outlined throughout this special issue and which for many participants, motivated the campaign described here.

There are already valid and effective alternative systems for identifying and describing psychological distress that may be helpful for the purposes of clinical practice, communication, record-keeping, planning and research, such as the operational definition of specific experiences or phenomena (Kinderman, Read, Bentall & Moncrieff, 2013). For clinicians, working in multidisciplinary teams, the most useful approach is that known as ‘collaborative formulation’ (British Psychological Society Division of Clinical Psychology 2011, Johnstone, 2014, Johnstone & Dallos, 2013). An individual formulation is a working hypothesis about the problem, which the person concerned develops in collaboration with a clinician. It consists of a summary of the individual’s problems and circumstances, hypothesis about their origins and possible therapeutic solutions. This ‘problem definition, formulation’ provides an alternative to the ‘diagnose and treat’ approach, which has the potential to yield the same benefits without the many inadequacies and dangers of the current approach.

Of course, psychology, at least as much psychiatry, is rooted in Western notions of scientific rationalism, and just as influenced by social and political context – so in the present

times, neoliberal thinking in particular. Psychology is also therefore just as vulnerable to naivety about the culturally situated and specific nature of its ideas and methodologies. Robust and insightful critique of the diagnostic model may help in this respect. In practical terms, however, care must be taken to ensure that formulations are genuinely collaborative and co-produced with clients, rather than becoming another example of something ‘done to’ service users by professionals. A recent leaflet for the public suggests that; “...working on a formulation is like two people putting together a jigsaw...” (British Psychological Society, 2015b). It is important that this is not an expert imposition of a particular scientifically and professional privileged point of view, but rather a collaborative exploration of possible explanations and solutions.

This paper began with a quote from 1854. It seems fitting (in a historical account) to end with a quote from Herman Melville’s unfinished 1891 novel ‘Billy Budd’:

“Who in the rainbow can draw the line where the violet tint ends and the orange tint begins? Distinctly we see the difference of the colors, but where exactly does the one first blendingly enter into the other? So with sanity and insanity. In pronounced cases there is no question about them. But in some supposed cases, in various degrees supposedly less pronounced, to draw the exact line of demarkation few will undertake tho’ for a fee some professional experts will. There is nothing nameable but that some men will undertake to do it for pay”.

This last point – ‘some men will undertake to do it for pay’ is perhaps important. We started this paper with a description of how social and economic factors, as much as scientific factors, appear to have influenced the development of psychiatric diagnosis. The linkage of profit, power and status to the use of diagnosis is surely important (Whitaker & Cosgrove, 2015)... if outside the scope of this paper.

So what should we do now? One direct and clear suggestion (taken from a recent book by the first author: Kinderman, 2014, p 186) is that: "... services should... be based on the premise that the origins of distress are largely social... should replace 'diagnoses' with straightforward descriptions of problems, ... should tailor help to each person's unique and complex needs... and should offer care rather than coercion" (p. 197).

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